# Managing Case Loads and Transitioning Participant Contributions in Support at Home

Lorraine Poulos
Managing Director LPA

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# Acknowledgement of Country

**I acknowledge the traditional owners of the land on which we do our work today**

**We pay our respects to their elders, past, present and emerging.**

**We also acknowledge the Traditional Custodians of the various lands on which you all work today and the Aboriginal and Torres Strait Islander people here today**

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# LPA Values

## Courage

We fearlessly embrace challenges, inspiring personal growth and contributing to the organisation's progress

## Integrity

At LPA, we prioritise doing what's right, not what's easy.

## Kindness

At LPA, we value understanding, care, and generosity to build strong relationships within our team, clients, and community.

## Respect

At LPA, we recognise the importance of others' thoughts, feelings, and backgrounds to our own, which enables understanding and collaboration.

## Gratitude

LPA team members approach every interaction with humility and appreciation, and are grateful for the opportunity to make a positive impact.

## Reliability

LPA values delivering on commitments with consistency. Our team is trustworthy, dependable, and highly engaged.

# Presentation overview

- Managing caseloads with pooled care management
- Scenarios for ‘expected’ contributions for transitioning and future care recipients in Support at Home

# Assumptions re current reform landscape

1. Bi-partisan support for Support at Home – minor tweaks
2. Home Care needed to change- unspent funds, misuse of funds, long waitlists etc.
3. Most providers are aware of main changes and have commenced making key changes to systems and processes
4. This is **a major** overhaul of aged care
5. Introduction of Support at Home has been delayed multiple times
6. We will not get it ‘right’ on November 1st 2025
7. **Policy Intent**: critical health needs are free, essential personal support is low cost, and more lifestyle services have higher user pays for those who can afford to contribute to their care.

# What has LPA been doing with providers?

- Reviewing the current viability and structures of services and advising on efficiencies
- Training care management teams
- Presenting to Boards and Management about opportunities and threats re S@H
- Facilitating planning days
- Tailored support
- Assistance with preparing for new models of care
- Assisting software companies to adjust
- Providing clinical supervision and support

And much more……

# Reform Headlines - Support at Home Program

- Package management fee eliminated; administrative costs and lost care management income to be accounted for in service price
- Care management funding based on 10% of classification funding level - pooled for flexibility
- A more ‘clinically focused’ model of care management
- New participant contributions framework, increased contributions for some participants, ‘no worse-off’ principle for existing participants
- Revised service categories – clinical care, independence, everyday living, defined service list
- Dedicated assistive technology and home modifications scheme

# Care & Services in the Support at Home Program

| Support at Home Service Types | |
|---|---|
| Clinical Services | Allied Health and other Therapeutic Services |
| | Nursing Care |
| | Nutrition |
| | Care Management |
| | Restorative Care Management |
| Independence Services | Personal Care |
| | Social Support and Community Engagement |
| | Therapeutic Services for Independent Living |
| | Respite |
| | Transport |
| | Assistive technology and home modifications |
| Everyday Living Services | Meals |
| | Domestic Assistance |
| | Home Maintenance and Repairs |

Source: DOHAC -Support at Home program update September 2024 – webinar slides page 20.

# What's New for Care Managers and Providers?

- **Eight Funding Levels:** SAH introduces 8 funding classifications (instead of 4 HCP levels) with **annual budgets** ~$11k to $78k (indicative) allocated per participant. Care managers must understand these new levels.

- **Quarterly Budgets:** Funding is released quarterly, not as a continuous accrual. There's limited carryover (up to 10% or $1,000) to next quarter. **Planning per quarter** is a new discipline in budgeting.

- **Mandatory Care Management (10%):** All participants receive care management services. **10% of each quarterly budget is automatically allocated** to a pooled care management fund. This is a shift from optional or varied care management charges under HCP.

# Challenges & Opportunities for Providers

- **Challenge – Navigating Change:** Adapting to new program rules and systems (funding, assessments, IT systems) can disrupt routines. **Workload may increase** initially (learning curve, transitioning clients).

- **Challenge – Participant Communication:** Explaining changes to clients and families – e.g. new budget levels, why co-payments exist, changes in services – requires clear, empathetic communication to avoid confusion or anxiety.

- **Opportunity – Holistic Care:** Integrated service streams encourage a whole-person approach. **Care plans can be more comprehensive**, combining clinical care with daily living support seamlessly. This can improve outcomes and client satisfaction.

# Subsidy amounts

| Classification | Quarterly Budget | Annual Amount |
|---|---|---|
| 1 | $2,674.18 | $10,697.72 |
| 2 | $3,995.42 | $15,981.68 |
| 3 | $5,479.94 | $21,919.77 |
| 4 | $7,386.33 | $29,545.33 |
| 5 | $9,883.76 | $39,535.04 |
| 6 | $11,989.35 | $47,957.41 |
| 7 | $14,530.53 | $58,122.13 |
| 8 | $19,427.25 | $77,709.00 |

# Restorative Care Pathway and End of Life

| Service | Budget amount |
| --- | --- |
| Restorative Care Pathway | $6,000 (up to 16 weeks). Can be increased to $12,000, when eligible. |
| End-of-Life Pathway | $25,000 (up to 16 weeks). |

# HCP vs SAH Classification levels

| HCP Level | HCP Quarterly subsidy | SHP Classification | SHP Quarterly budget | SHP care management Quarterly (10% capped) |
|---|---|---|---|---|
| **HCP 1** | $ 2,674.54 | 1 | 2,674.18 | $ 267.42 |
| **HCP 2** | $ 4,703.03 | 2 | 3,995.42 | $ 399.54 |
| | $ - | 3 | 5,479.94 | $ 547.99 |
| | $ - | 4 | 7,386.33 | $ 738.63 |
| **HCP 3** | $ 10,236.43 | 5 | 9,883.76 | $ 988.38 |
| | $ - | 6 | 11,989.35 | $ 1,198.94 |
| **HCP 4** | $ 15,518.89 | 7 | 14,530.53 | $ 1,453.05 |
| | $ - | 8 | 19,427.25 | $ 1,942.73 |

# Care Management Goals in Support at Home

*(Reference: S@H Program manual V2, p61)*

- Improved aged care outcomes
- Enhanced continuity of care
- Increased participant satisfaction
- **Optimise use** of resources
- Empowered self management
- Engaged carers and supporters

# Care Management and Care Partners

- Care Management is a **process** with various steps and elements based on a case management model
- Care Partners **undertake** certain steps and functions within that process – it may be the majority of the tasks but not all.

# Billable Care Management activities

| Billable Activities | Description |
|---|---|
| Care planning | • Identifying participant needs, goals, preferences and existing supports<br>• Reviewing the participant's support plan and assisting the participant to understand their approved services<br>• Developing and reviewing care plans and quarterly budgets<br>• Establishing and reviewing service agreements<br>• Conducting risk assessments in relation to the participant and their home<br>• Supporting the participant to complete and review advance care planning documents, if appropriate or required |
| Service planning and management | • Communication with aged care workers (involved in the delivery of services) regarding the participant's needs and wellbeing<br>• Incorporating cultural protocols including engaging with culturally specific organisations<br>• Communication with the participant, their carers and supporters<br>• Managing the quarterly budget to ensure no overspends<br>• Ordering client consumables<br>• Facilitating transitions in and out of different care settings and ensuring continuity of care |
| Monitoring, review and evaluation | • Engaging in ongoing care discussions and/or case conferencing with relevant health professionals, where required<br>• Regular review of the participant's care notes<br>• Monitoring and responding to changing needs<br>• Identification of risks to the participant's health, safety and wellbeing and ongoing management of those risks<br>• Evaluating the participant's goals, service quality and outcomes |
| Support and education | • Supporting participants (and their carer or supporter) to make informed decisions, including respecting their right to take risks, as per the supported decision-making framework<br>• Supporting delivery of services with wellness and reablement approaches<br>• Providing independent advice, information and resources on aged-related health matters<br>• Health promotion information and education<br>• Supporting participants to navigate age-related systems and programs and linking them to additional supports<br>• Ensuring participant views, rights and concerns are heard and escalated, including in relation to complaints<br>• Supporting the participant with providing feedback and complaints |

# Non-Billable Activities

Non-billable activities often include tasks that are **essential for operational efficiency but not directly related to a specific client's care** or not allowable under funding guidelines. Here are some examples:

- general administrative duties not directly related to a specific client's care, such as scheduling/rostering of care workers, internal meetings, and staff training
- time spent in meetings that does not involve direct client care or is not specific to a client's needs
- completing internal forms or compliance documentation unrelated to a specific client
- attending community forums or industry events without a direct service provision component

# Care Partners

- Where a provider employs both care partners and clinically-qualified care partners, **the care partner may undertake the majority of care management activities with the participant**. However, some participants with more complex care needs may have their service coordination and care planning overseen by a clinically-qualified care partner. For example, a provider may choose to appoint a clinically-qualified care partner for all participants receiving services under the End-of-Life Pathway or for all participants with a classification of level 6 or higher.
- The role of a care partner and/or a clinically-qualified care partner should be **outlined in the provider's clinical governance framework** and should include activities for effective implementation of Standard 1 (Outcomes 1.1-1.3) and Standard 5 (Outcome 5.1) of the strengthened Quality Standards. Information to support effective implementation for these outcomes is on the Commission's website at Draft Strengthened Quality Standards Guidance.

S@H Manual V2 p 69-78

# Pooled care management: how it works

- **10% pooled fund:** 10% of each client's funding is set aside for care management and held in a **pooled account**. Providers (through their Care Partners) then **claim** from this pool when they carry out care management activities (e.g. assessments, arranging services, client check-ins)
- **Flexible use across clients:** the pool can be used **flexibly across participants**. This means the Care Partner can allocate more time to clients who need it and less to those who are more independent, without worrying about exceeding an individual's tiny budget for case management. In effect, low-need clients subsidise higher-need clients' care management to some extent, ensuring everyone gets appropriate support

# Pooled care management: how it works

- **Accountability:** even though funding is pooled, Care Partners must **document activities** per client to make claims. For instance, a case note of a home visit or phone call will justify the claim for that time.
- All participants must get at least **one care management interaction per month**, so the pool will be drawn from regularly. Providers will have to track usage to ensure the 10% pool is not exhausted disproportionately

# Suggestions for managing care management pool

- Most providers now operate a ‘pooled’ care management model wherein some consumers/participant utilise varying amounts of care management allocation- you can continue with this model
- Changes will need to be made to capture activities for invoicing Services Australia
- Allocate expected targets for your case load based on **acuity, risk and vulnerability**
- You need to provide a care management activity monthly

# LPA suggestions

- Try NOT to think of each participant having an allocation of hours
- There is a pool of funding and units will be claimed by providers over a 12-week period
- It is important to have a **system in place for accountability** of tasks undertaken by various team members
- Your goal is to optimise all available funding for care management according to the Support at Home guidelines and ensure we are available for participants when needed.
- Tracking of tasks is a very common method in professional services and will become easier overtime for care partners

# Case study

- Alex is an experienced care manager
- He/she has a case load of **30** HCP consumers

**Quarterly Care Management income pre November 2025**

- 20 Level 2 - CM income $9,398
- 5 Level 3 - CM income $20,454
- 5 Level 4 - CM income $31,008
- Total income for the quarter for Care Management is around $61K
- Post November reduces to $30.5K
- Alex now has to account for the care management activities, ‘juggle’ case management hours to ensure the maximum allocation is not exceeded, and that the requirements of care management are met.
- Some billable items may be undertaken by others. How will you manage who is doing what and how are you accounting for this?

# Determining and Quantifying Care Management inputs

LPA suggests

- Establish current care management inputs for each participant and your available ‘pool’
- Breakdown care management inputs by:
  - activity: care planning, service planning and management, monitoring, review and evaluation, support and education
  - duration
  - frequency
  - Participant

  *Time in Motion study

Duration x frequency x participant= volume of CM hours per year for each input type

# Managing your caseload effectively

- **Prioritise by need:** not all clients require the same level of attention. A best practice is to **stratify your caseload** by risk or vulnerability. Identify clients who are high-risk (e.g. living alone with cognitive impairment, recent hospitalisations, multiple chronic illnesses, signs of self-neglect) versus low-risk (e.g. good family support, stable health). High-risk clients should get more frequent and proactive contact
- **Create a schedule:** use the monthly minimum contact as a baseline and **build a schedule** for each client. For example: high-need client – weekly check-in (even brief), medium-need – biweekly or monthly, low-need – monthly. Adjust as situations change. A visual roster or spreadsheet **(eg: LPA's Time and Motion planner)** can help track when each client was last contacted and when the next is due

# Care Management  Claiming Business Rules

## 3.4 Care management account

### 3.4.1 HL-CMF-1 Manage care management account

**Description**

Services Australia to validate, calculate, pay, and maintain care management accounts.

**Business value**

A separate care management account which providers are paid from on a payment in arrears basis.

Older people in Support at Home will have 10% of their ongoing quarterly budget quarantined for care management. This funding will be retained and redistributed to providers, based on the participants in their care.

Providers will have a notional care management account, which is credited at the start of every quarter. They claim against the credits in the account.

Services Australia will manage the provider's care management account, including establishing the account, calculating credits made, and payments made to the provider. Upon receiving the claim, Services Australia will validate and manage payments.

When claiming from the care management account, a Provider needs to be registered to provide the care management services.

# Care management information example for a budget statement

- *"Your provider has also carried out care management activities which include working with you to plan and coordinate your services, making sure your services are working well for you, resolving problems, adjusting services for your changing needs and connecting you to other services and supports. Care management includes time spent on documentation and following up agreed actions. An itemised list of care management activities can be found in the Support at Home Program Manual.*
- *Your provider will have charged these services to their care management fund. Your provider is responsible for providing you at least one care management activity per month.*
- *If you are only accessing the Restorative Care Pathway, you will receive restorative care management, rather than care management. Restorative care management service information will be displayed below."*

*Source: DoHA Sample Support at Home monthly statement example April 2025*

# Care Management and statements

At this stage (May-June 2025) providers will not be required to **indicate on statements to participants** how much care management was provided only that a 10% drawn down has occurred

**HOWEVER**

Providers will be required to justify to Services Australia what care management activities were undertaken for each participant and how much time.

There is a need for an efficient tracking system so that all billable hours are justified.

There will be no place for “double dipping” or **"Receiving overlapping payments"** (e.g., *There may be a risk of receiving/claiming  overlapping payments for the same service.*)

e.g. you will need to demonstrate **who** provided the care management activities and **what** the service was and **when** they were delivered and for **how long** in your internal system

# Care Management checklist

# Managing Participant Contributions

- Contributions apply only to services used **will be deducted** from participant subsidies
- Providers must collect **contributions post-service**, with systems for invoicing, recording, and subsidy claims
- Clear communication on fees, including government-set fees, requires careful **change management**
- Cost of collecting, previously covered by package management fees, are now included in service prices

# Participant Contributions – The New Fee Framework

- **Means-Tested Co-Contributions:** Under SAH, participants may pay a share of service costs based on their financial means and service type. This replaces HCP income-tested fees  with a unified model.
- **Three Contribution Categories:** Fees are structured by service category:
  - ***Clinical Supports***: **No co-payment**. The government covers 100% of clinical services like nursing, allied health, and care management.
  - ***Independence Services***: **Moderate contribution**. Participants pay a percentage (sliding scale) for services that help maintain independence (e.g., personal care, therapy for independent living, transport). Full pensioners pay a low rate 5% others pay more up to 50% depending on income/assets.
  - ***Everyday Living Services***: **Higher contribution**. For supports like cleaning, gardening, shopping help, contributions range from 17.5% (full pensioners) up to **80% for high-income self-funded retirees**.

- **No Worse Off Guarantee:** If a client was in home care as of 12th Sept 2024, they will not pay more in SAH than they would have under the old system. This transitional safeguard means many existing full pensioners will continue to pay $0 or minimal fees.

- **Contribution Caps:** There will be **annual and lifetime caps** on what individuals pay (e.g., no one will pay more than a set amount in their lifetime for care). This ensures affordability and fairness even for long-term high users of services.

# Support at Home transition arrangements for home care recipients: 6 distinct categories for budgeting

*Source: S@H Manual, V2 (July replaced with November)*

| Categories | Approved for HCP before 12.9.24 announcement | Receiving HCP before 1 November2025 | Does / would the individual pay an income-tested care fee under HCP | Support at Home fees for that individual |
|---|---|---|---|---|
| **Category A: HCP non-income tested care fee payer, or person on the NPS or approved for a package who would be a non-fee payer once they receive a package** | Yes | Yes | No | No fees. |
| **Category B: HCP income tested care fee-payer, or person on the NPS or approved for a package who based on their means would be a fee-payer once they receive a package** | Yes | Yes | Yes | These recipients will be protected by the no worse off principle and pay discounted contribution rates (see next slide). **This category ONLY, will have a preserved contribution rate** |
| **Category C: Person assessed but not approved for HCP and on the queue for HCP income means assessment, at 12.9.24 announcement** | No | Unknown | Unknown (but they're on the queue for income assessment) | Older person gets a HCP means assessment – moves to the Support at Home contribution arrangements from 1 November2025, regardless of whether they receive an HCP before 1 November2025. |
| **Category D: new HCP entrant after 12.9.24 announcement – HCP fee payer** | No | Yes | Yes | Older person will pay the regular rates from 1 November2025 |
| **Category E: new HCP entrant after 12.9.24 announcement – HCP non-fee payer** | No | Yes | No | Older person will pay the regular rates from 1November2025 |
| **Category F: new entrants after Support at Home commences** | No | No | No | Older person will pay the regular rates |

# Considerations


Support at Home program claims and payments business rules guidance

Stage 1 - July 2025

- Providers will need to review all areas of operations of their business (227 business rules in the claims and payments rules guidance)

- Business rules will apply to the following:

  - ✓Current HCP participants transitioning to S@H
  - ✓HCP participants who have HCP approval after 12th September 2024
  - ✓New Support at Home participants entering with new funding classification
  - ✓Current CHSP clients and new CHSP clients

All with different funding allocations, contribution rates and prices for services set by providers (until IHACPA prices are determined)

# Examples of changes for new and transitioning participants

**Current:**

Full pensioner, **pre-September 12th, 2024**, HCP, no contribution fees, unspent funds.

What happens post November 2025?

1. No changes to contribution rates
2. New prices set by Provider
3. S@H equivalent funding classification
4. If current care needs exceed allocated S@H funding with new prices set by provider, THEN unspent funds are accessed
5. Once all unspent funds are utilised then reassessment can be sought

Full pensioner, **post-September 12th, 2024**, HCP, no current contribution fees, unspent funds.

**What happens post November 2025?**

1. New contribution rates according to service type rates (for transitioning participants this may be a 'shock')
2. Contribution rates a % of service type – 5% for independence services, 17.5% for everyday living
3. New prices set by Provider
4. S@H equivalent funding classification
5. If current care needs exceed allocated S@H funding THEN unspent funds are accessed
6. Once all unspent funds (if any accrued) are utilised then reassessment can be sought for higher classification)

# Examples - new and transitioning participants

**Current:**

SFR or Part Pensioner **pre-September 12th, 2024**, HCP, ITA fees, unspent funds.

What happens post November 2025?

1. Contribution rates **cannot exceed current ITA-** may be less for some depending on service types
2. Contribution rates are based on what services are used NOT a daily fee as is the case pre-November 2025
3. New prices set by Provider
4. S@H equivalent funding classification
5. If current care needs exceed allocated S@H funding THEN unspent funds are accessed
6. Once all unspent funds are utilised then reassessment can be sought
7. Still no higher fees then current ITA

SFR or Part Pensioner, **post-September 12th, 2024**, current ITA daily fee, unspent funds.

**What happens post November 2025?**

1. New contribution rates according to service type rates (nil clinical, **up to 5-50%independence**, from **17.5% up to 80%% everyday living**)
2. Contribution % set by Services Australia
3. New prices set by Provider
4. S@H equivalent funding classification
5. If current care needs exceed allocated S@H funding THEN unspent funds are accessed
6. Once all unspent funds are utilised then reassessment can be sought

# LPA hypothetical example

**Post November fees (assuming approved AFTER September 12th 2024)**

**Hypothetical** price $100 per hour of service ( some services will be less some more)

**Per week example Full Pensioner:**

5 showers x$100 @5% cost = **$25**

2 Hours domestic assistance x $100 @ 17.5% of cost = **$35**

2 hours shopping x $100 @ 5% of cost **=$10**

**Total cost to participant = $70 per week**

**Per week Full Self Funded Retiree ( assuming highest income and means level)**

5 showers x$100 @ 50%of cost **=$250**

2 Hours domestic assistance x $100 @ 80% of cost **= $160**

2 hours shopping x $100 @ 50% of cost **= $100**

**Total cost to participant = $510**

Remember **there are many variables to this scenario** however it is an example of the possible future impact on cost to older Australians to contributing to the cost of their care.

- **Practical Application:** Providers will need to **calculate and collect these fees**. My Aged Care or Services Australia will determine each participant's co-pay rate (similar to income assessments) and providers need to include this in their budget.
- E.g., if a service costs $100 and participant owes 20%, Government covers $80. Providers should be prepared to explain fees to clients and incorporate client contributions into budget discussions.

# Key Messages

- Contributions may differ per service type, adding complexity to management
- A review of systems and resources for fee collection is advisable
- Failure to collect contributions risks providers' ability to deliver full SAH services and impacts financial sustainability
- ‘Participant Service Agreement’ will need to include very clear terms and conditions – get legal advice
- Credit control measures will be critical

## WHAT PROVIDERS ARE SAYING

"We will look at lawyer billing systems"

"we are worried that older Australians will refuse services if they have to contribute high fees"

"Perhaps there are non-billable tasks that a lower-cost employee can complete instead of Care Managers or regular tasks that can be automated with technology"

"Our billing to Services Australia must be accurate. We need to ensure all our clients get their fair share of Care Management over the quarter"

"I am testing 15mins unit timesheet to find out exactly what my Care Managers do so we can find solutions so more of their tasks can be billable and a lower cost employee can do non-billable tasks"

"Accurate tracking of billable hours ensures we don't overcharge the Govt and gives us the opportunity to identify how we can operate more efficiently, which improves sustainability of the 10% care management levy"

"Care managers will have to communicate better with management and IT so that we can improve their workflows and reduce the time it takes to do their role in a compliant and professional fashion"


# THANK YOU

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03 (02) 9337 2337